Reset Form

# APPLICATION FOR REGISTRATION AS SPEECH-LANGUAGE PATHOLOGY SUPPORT PERSONNEL

State Form 53764 (11-08)
Approved by State Board of Accounts, 2008


**SPEECH LANGUAGE PATHOLOGY AND AUDIOLOGY BOARD**
**PROFESSIONAL LICENSING AGENCY**
402 West Washington Street, Room W072
Indianapolis, Indiana 46204
Telephone: (317) 234-2064
Website: www.pla.in.gov


*INSTRUCTIONS:*

1. *Please type or print legibly.*
2. *Answer all questions.*

* Your Social Security Number is being requested by this state agency in accordance with IC 4-1-8-1. Disclosure is mandatory and this record cannot be processed without it. Social Security Numbers are available to the Indiana Department of Revenue.

| FOR OFFICE USE ONLY | |
|---|---|
| **APPLICATION FEE** | |
| **DATE FEE PAID (*month, day, year*)** | |
| **RECEIPT NUMBER** | |
| **REGISTRATION NUMBER** | |
| **DATE ISSUED (*month, day, year*)** | |

ATTACH ONE (1) PASSPORT QUALITY PHOTOGRAPH HERE

**DO NOT WRITE ABOVE THIS LINE**

Type of application (*please check one only*) ☐ **Aide** ☐ **Associate** ☐ **Assistant**

## APPLICANT INFORMATION

| Name of applicant (*last, first, middle, maiden or previous name*) | | Social Security Number * |
|---|---|---|
| Address (*number and street or rural route*) | | |
| City | State | ZIP code |
| Date of birth (*month, day, year*) | Place of birth (*city and state*) | |
| Residential telephone number (*include area code*) ( ) | E-mail address | |

## SUPERVISOR(S) INFORMATION

Name of supervisor

Name of supervisor

Name of supervisor

## SUPPORT PERSONNEL REGISTRATION(S) ISSUED

Do you hold or have you held a registration as a speech-language pathology aide, associate or assistant? ☐ Yes ☐ No
If yes, list registration number, date issued, date expired, and supervisor's name.

| REGISTRATION NUMBER | ISSUE DATE (*month, day, year*) | EXPIRATION DATE (*month, day, year*) | SUPERVISOR'S NAME |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

*(Continued on reverse side)*

## SUPPORT PERSONNEL REGISTRATION(S) ISSUED (*continued*)

*Please list all levels of education you have attended.*

| NAME OF SCHOOL | LOCATION OF SCHOOL | DATES ATTENDED (*month,day, year*) | DEGREE GRANTED |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

If your answer is "Yes" to any question below, explain fully in a signed and notarized statement, including all related details. Include the violation, location, date, and disposition. Include all relevant court documents, if applicable. Letters from attorneys are not accepted in lieu of your statement. Falsification of any of the following is grounds for permanent revocation of a license issued pursuant to this application.

1. Have you ever previously filed an application in the State of Indiana? ☐ Yes ☐ No
2. Has disciplinary action ever been taken regarding any health license, certificate, registration or permit that you hold or have held? ☐ Yes ☐ No
3. Have you ever been denied a license, certificate, registration or permit to practice speech-language pathology or audiology or any regulated health occupation in any state (*including Indiana*) or country? ☐ Yes ☐ No
4. Are you now being or have you ever been treated for drug or alcohol abuse? ☐ Yes ☐ No
5. Have you ever been convicted of, pled guilty or *nolo contender* to:
   A. A violation of Federal, State or local law relating to the use, manufacturing, distribution or dispensing of controlled substances or drug addiction? ☐ Yes ☐ No
   B. Any offense, misdemeanor or felony in any state? ☐ Yes ☐ No
6. Have you ever been denied staff membership or privileges in any hospital or health care facility or had such membership or privileges revoked, suspended or subjected to any restrictions, probation or other type of discipline or limitations? ☐ Yes ☐ No
7. Have you ever been admonished, censured, reprimanded or requested to withdraw, resign or retire from any hospital or health care facility in which you have trained, held staff membership or priveleges or acted as a consultant? ☐ Yes ☐ No
8. Have you ever had a malpractice judgment against you or settled any malpractice action? ☐ Yes ☐ No

## APPLICATION AFFIRMATION

I hereby swear or affirm, under the penalties of perjury, that the statements made in this application are true, complete, and correct. I am aware of the requirements set forth in 880 IAC 1-2.1 and understand that I may practice as speech-language pathology support personnel, under the direct supervision of the person whose name appears on this application, until the expiration of my registration as an aide, associate, or assistant.

| Signature of applicant | Date signed (*month, day, year*) |
|---|---|
| | |

## AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize, request, and direct any person, firm, officer, corporation, association, organization or institution to release to the Professional Licensing Agency, any files, documents, records or other information pertaining to the undersigned requested by the Agency or any of its authorized representatives in connection with the processing of my application for a registration as speech-language pathology aide, associate, or assistant.

I hereby release the aforementioned persons, firms, officers, corporations, associations, organizations, and institutions from any liability with regard to such inspection or furnishing of any such information.

A photostatic copy of this authorization has the same force and effect as the original.

## AFFIRMATION

I hereby swear and affirm that I have read the above statements and agree to the same.

| Signature of applicant | Date signed (*month, day, year*) |
|---|---|
| | |

# FORM SLP-1
# VERIFICATION OF SPEECH-LANGUAGE SUPPORT PERSONNEL SUPERVISOR'S INFORMATION

Part of State Form 53764 (11-08)
Approved by State Board of Accounts, 2008

*INSTRUCTIONS:*

1. *Complete **SECTION A** and forward this form to your field supervisor.*
2. ***SECTION B** must be completed by a speech-language pathologist licensed by the board.*
3. *List any additional work site addresses on a separate sheet of paper.*

| SECTION A / APPLICANT INFORMATION | |
|---|---|
| Name of applicant (*last, first, middle, maiden or previous name*) | Social Security Number * |

Level of supervision (*please check one only*) ☐ **Aide** ☐ **Associate** ☐ **Assistant**

| SECTION B / SUPERVISOR'S INFORMATION | | |
|---|---|---|
| Name of supervisor (*last, first, middle, maiden or previous name*) | | Social Security Number * |
| Indiana license number | | Date of expiration (*month, day, year*) |
| Address (*number and street or rural route*) | | |
| City | State | ZIP code |
| Residential telephone number (*include area code*) ( ) | E-mail address | |

| NAME OF SCHOOL / HOSPITAL / FACILITY / COMPANY WHERE THE SUPPORT PERSONNEL WILL BE EMPLOYED | | |
|---|---|---|
| Name of school / hospital / facility / company | | |
| Address (*number and street or rural route*) | | |
| City | State | ZIP code |
| Residential telephone number (*include area code*) ( ) | E-mail address | |

| ADDRESS OF LOCATION WHERE SERVICES WILL BE PROVIDED | | |
|---|---|---|
| Address of location (*number and street or rural route*) | | |
| City | State | ZIP code |

| SUPPORT PERSONNEL CURRENTLY REGISTERED UNDER YOUR LICENSE | |
|---|---|
| *Please list the support personnel name(s) and registration number(s) currently registered under your license.* | |
| NAME | REGISTRATION NUMBER |
| | |
| | |
| | |

*(Continued on reverse side)*

## SUPERVISION OF SPEECH-LANGUAGE PATHOLOGY SUPPORT PERSONNEL

1. Support personnel's level of academic training.

2. Specify method of supervision.

3. Specify training program.

4. Specify all procedures to be performed by the suppport personnel.

5. Describe in detail the pertinent educational and work experience for the support personnel for which authorization is sought.

## APPLICATION AFFIRMATION

I hereby swear or affirm under the penalties of perjury, that the statements made in this application are true, complete, and correct. I shall be responsible for the direct supervision of the support personnel for whom this application is submitted in compliance with requirements set forth in IC 25-35.6-1-2 (g) and 880 IAC 1-2.1.

| Signature of supervisor | Date signed (*month, day, year*) |
| --- | --- |
| | |

# FORM A-1
# VERIFICATION OF SLP SUPPORT PERSONNEL FIELD EXPERIENCE - ASSOCIATE

Part of State Form 53764 (11-08)
Approved by State Board of Accounts, 2008

*INSTRUCTIONS:*

1. *Complete **SECTION A** and forward this form to your filed supervisor.*
2. ***SECTION B** must be completed by an official of the institution that has granted you the academic credit for this supervised field experience.*
3. ***Return this form to:***

Indiana Professional Licensing Agency
402 West Washington Street, Room W072
Indianapolis, IN 46204

## SECTION A / APPLICANT INFORMATION

| Name of applicant (*last, first, middle, maiden or previous name*) | Social Security Number * |
|---|---|
| | |

My minimum one hundred (100) hour supervised field experience was completed under the auspices of the following educational institution:

_____ located at _____
*Name of Institution* *City and State*

I completed the supervised field experience between the following dates:

_____ _____
*Date began (month/year)* *Date completed (month/year)*

I completed the supervised field experience at the following location:

_____
*Specific location of field experience*

## SECTION B / VERIFICATION OF COMPLETION OF THE ONE HUNDRED (100) HOUR FIELD EXPERIENCE

As an official of the school named above, I certify that the above-named applicant has completed at least the following experience during the completion of the supervised field experince:

(1) Applicant has completed at least a one hundred (100) hour field experience that enabled the applicant to develop the core technical skills needed to assist in the treatment of communication disorders.

As an official of the school named above, I certify that the above-named applicant was evaluated throughout the field experience and the applicant's performance was satisfactory.

I further certify that the supervision for this field experience was conducted by either a program faculty member or a supervisor working under the supervision of a program faculty member. The applicant's supervisor(s) held the following position(s), degree(s), license(s), and/or certification(s) - [*Provide name(s) and qualification(s) below]:*

| Program faculty member | |
|---|---|
| Alternate supervisor | |
| Site supervisor | |
| Position held at the institution | Name of institution |
| Name (*last, first, middle, maiden or previous name*) | |

# FORM A-2
# VERIFICATION OF CLINICAL EXPERIENCE FOR SLP SUPPORT PERSONNEL - ASSISTANT

Part of State Form 53764 (11-08)

Approved by State Board of Accounts, 2008

*INSTRUCTIONS:*

1. *Complete **SECTION A** and then forward this form to your previous or current speech-language pathologist (SLP) supervisor(s) for completion of **SECTION B**.*
2. *Submit proof that you have acquired at least one hundred (100) hours of clinical experience.*
3. *This form may be duplicated if your one hundred (100) hours of experience have been completed under more than one (1) SLP supervisor.*
4. ***SECTION B** must be completed by the applicant's previous or current supervisor, notarized, and sent directly to:*

Indiana Professional Licensing Agency
402 West Washington Street, Room W072
Indianapolis, IN 46204

| SECTION A / APPLICANT INFORMATION | |
|---|---|
| Name of applicant (*last, first, middle, maiden or previous name*) | Social Security Number * |
| Name of SLP supervisor (*last, first, middle, maiden or previous name*) | License number of SLP supervisor |
| Location of clinical experience | Dates of clinical experience (*month, day, year*) |

| SECTION B / CLINICAL EXPERIENCE / SUPERVISOR'S INFORMATION | |
|---|---|
| Total number of hours the above-named applicant served in the clinical experience | Total number of hours obtained with direct face-to-face patient/client contact |
| Number of hours of direct face-to-face patient/client contact in speech disorders obtained by the above-named applicant | Number of hours of direct face-to-face patient/client contact in language disorders obtained by the above-named applicant |
| I swear that the above information is true and correct to the best of my knowledge and belief. | |
| Signature of SLP supervisor | |
| Printed name of SLP supervisor | |
| Date signed (*month, day, year*) | |
| Daytime telephone number<br>( ) | |

| | |
|---|---|
| Signature of Notary Public | SEAL<br>OF<br>NOTARY PUBLIC |
| Printed name of Notary Public | |
| Expiration of commission (*month, day, year*) | |
| County of residence | |